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Religion, Sense of Calling, and the Practice of Medicine: Findings from a National Survey of Primary Care Physicians and Psychiatrists

John D. Yoon, MD, Jiwon H. Shin, MA, Andy L. Nian, BS, and Farr A. Curlin, MD

Department of Medicine, Section of Hospital Medicine, University of Chicago, Chicago, Illinois, the University of California School of Medicine, Irvine, the Feinberg School of Medicine, Northwestern University, Chicago, Illinois, and the Trent Center for Bioethics, Humanities, and History of Medicine, Duke University, Durham, North Carolina

Abstract

Objectives—A sense of calling is a concept with religious and theological roots; however, it is unclear whether contemporary physicians in the United States still embrace this concept in their practice of medicine. This study assesses the association between religious characteristics and endorsing a sense of calling among practicing primary care physicians (PCPs) and psychiatrists.

Methods—In 2009, we surveyed a stratified random sample of 2016 PCPs and psychiatrists in the United States. Physicians were asked whether they agreed with the statement, “For me, the practice of medicine is a calling.” Primary predictors included demographic and self-reported religious characteristics, including attendance, affiliation, importance of religion, intrinsic religiosity) and spirituality.

Results—Among eligible respondents, the response rate was 63% (896/1427) for PCPs and 64% (312/487) for psychiatrists. A total of 40% of PCPs and 42% of psychiatrists endorsed a strong sense of calling. PCPs and psychiatrists who were more spiritual and/or religious as assessed by all four measures were more likely to report a strong sense of calling in the practice of medicine. Nearly half of Muslim (46%) and Catholic (45%) PCPs and the majority of evangelical Protestant PCPs (60%) report a strong sense of calling in their practice, and PCPs with these affiliations were more likely to endorse a strong sense of calling than those with no affiliation (26%, bivariate $P < 0.001$). We found similar trends for psychiatrists.

Conclusions—In this national study of PCPs and psychiatrists, we found that PCPs who considered themselves religious were more likely to report a strong sense of calling in the practice of medicine. Although this cross-sectional study cannot be used to make definitive causal inferences between religion and developing a strong sense of calling, PCPs who considered themselves religious are more likely to embrace the concept of calling in their practice of medicine.

Keywords

religion; calling; primary care; psychiatry; spirituality

The notion of a “sense of calling” has been attracting increasing empirical and theological interest, with calling increasingly recognized as an intrinsic motivating factor that can help medical students and physicians sustain meaning and purpose in their work. Those who view work more as a calling than as a job tend to ascribe intrinsic or transcendent purpose and life meaning through their work.^{1–3} A few studies have found that seeking meaning in one’s work may be the key mediating variable in the relation between a sense of calling and work satisfaction; researchers in the fields of work motivation and positive psychology have found calling to be positively associated with measures of professional well-being, including work satisfaction, commitment, and performance.^{4,5}

Studies of medical students have found that students who endorsed a stronger sense of calling were more likely to express an interest in primary care⁶ and endorse a higher commitment to their specialty.⁷ Few studies, however, have explored the issue of a calling among practicing US physicians. One study of primary care physicians (PCPs) found an association between a sense of calling and experiencing satisfaction treating smoking, alcoholism, and obesity.⁸ Another study of practicing US physicians across various specialties, however, found no significant association between a sense of calling and practicing among underserved populations, although the latter study did find that physicians who considered themselves religious were more likely to view their practice of medicine as a calling.⁹

The notion of a calling shares the same Latin root as the word vocation (“voco, vocare, vocatus”), meaning “to summon, to call, to name, to call upon, to invite, to challenge.”¹⁰ In early Christianity, “calling” was used to describe a decision initiated by God, referring primarily to the calling one would receive to enter the ministry or religious work. In the 16th century, the idea of vocation or calling was explicitly extended from the clergy to all people,¹¹ as the Protestant reformers Martin Luther and John Calvin began attaching more spiritual significance to “earthly” work.¹² The concept of calling has evolved into a broader reference to any strong sense of purpose that keeps motivation alive; nourishes a proper sense of self-fulfillment; and enables one to work with a vision, namely that the impact of one’s work extends beyond the individual realm to benefit others, society, or a transcendent figure.¹³ Qualitative research has further specified a sense of calling as either a guiding force (eg, God’s will, a driving feeling), a sense of personal fit (eg, ability, personal enjoyment), or altruistic motivation.¹⁴ Most research, however, leaves the definition of calling open to interpretation by the individual.

The present study did not specify calling as a specifically religious concept, despite its religious and theological roots. Even so, we hypothesized that physicians who considered themselves religious would endorse a stronger sense of calling to their work than physicians who did not consider themselves religious, suggesting that the concept has particular resonance for those who are religious, even though “calling” is a familiar concept across

diverse moral communities. In the present study, we examined the association between religion and calling among a national sample of practicing PCPs and psychiatrists.

Methods

Between September 2009 and June 2010, we mailed a confidential self-administered questionnaire to a stratified random sample consisting of 1504 PCPs and 512 psychiatrists in the United States who were 65 years old or younger. The sample was generated from the American Medical Association Physician Masterfile, a database intended to include all practicing US physicians. This particular study was part of a larger study investigating physicians' opinions on various issues in mental and behavioral health.¹⁵ To increase Muslim, Hindu, and Jewish representation, we used validated ethnic surname lists^{16–18} to enhance the power of analyses that are not central to this study. Physicians received up to three separate mailings of the questionnaire. The first mailing included a \$20 bill and the third offered an additional \$30 for participation. All of the data were double keyed, cross-compared, and corrected against the original questionnaires. The study was approved by the University of Chicago institutional review board.

Questionnaire

The primary criterion variable was a measure of physicians' sense of calling. To make comparisons, we used a measure from previous studies.^{8,9,19} The measure asked respondents their agreement or disagreement with the following statement, "For me, the practice of medicine is a calling." Physicians were categorized as having a strong sense of calling if they indicated that they "agreed strongly" with this statement.

Primary predictors were measures of physicians' religious characteristics. We categorized religious affiliation as none/no religious affiliation, Hindu, Jewish, Muslim, Catholic (Roman Catholic [n = 253] or Eastern Orthodox [n = 27]), evangelical Protestant, non-evangelical Protestant, and other (including Buddhist [n = 24]). We also measured the frequency of attendance at religious services (response categories collapsed to never, once per month or less, and twice per month or more). We measured the importance of religion with the question, "How important would you say your religion is in your own life?" (not very important, fairly important, very important, or most important). For the purposes of our analyses, respondents who marked "not applicable/I have no religion" were categorized with those marked "not very important."

We measured spirituality by asking, "To what extent do you consider yourself a spiritual person?" Physician spirituality was categorized as high for those who marked "very spiritual," moderate for "moderately spiritual," and low for "slightly or not at all spiritual." In recent years, there has been a trend toward studying spirituality rather than religiosity. Spirituality is thought to be "broader" than religion such that many individuals who are not religious may still be spiritual.²⁰ Other research suggests that the concept of spirituality encompasses several different cultural "packages," some of which overlap with the concept of "religious."²¹ Because there is disagreement as to what spirituality means, we allowed physicians to respond using their own concept of spirituality to reduce survey burden.

We also assessed physicians' intrinsic religiosity by using two items from the Hoge Intrinsic Religious Motivation Scale.²² Respondents were asked their agreement or disagreement with two statements, "I try hard to carry my religious beliefs over into all my other dealings in life," and "My whole approach to life is based on my religion." Physician religiosity was categorized as low if the physician agreed with neither statement, moderate if the physician agreed with one but not the other, and high if the physician agreed with both statements. Covariates in our multivariate models included several demographic characteristics including age, sex, race/ethnicity, geographic region, and immigration history.

Statistical Analysis

Case weights were incorporated to account for unrepresentativeness deriving from the research design and differing response rates. A design weight was used to correct for the ethnic surname oversampling strategy, and a poststratification adjustment weight was used to correct for differences in response rates among the surname categories, among US versus foreign medical school graduates, and among physicians who described their practice as teaching/"other" versus practice types that included administration, research, office-based, resident/hospital-based, hospital staff/hospital based, or unclassified. Cases were weighted using the inverse probability of a person with the relevant characteristic being in the final dataset. The final weight for each case/respondent was the product of the design weight and the poststratification adjustment weight. This method of case weighting, widely used in population-based research,²³ enabled us to adjust for sample stratification and variable response rates to generate estimates for the population of US PCPs and psychiatrists, given no response bias. Weights were not calculated for the psychiatrist sample because no disproportionate sampling by surname strata was performed, and because response rates for background variables from the Masterfile did not differ significantly.

We used the χ^2 test to examine bivariate associations between each religious characteristic and whether a physician reported having a strong sense of calling. We then conducted multivariable logistic regression using the covariates mentioned above. Blank responses were omitted from the analysis of those items. All of the analyses were conducted using the survey-design-adjusted commands of Stata SE statistical software version 11.0 (StataCorp, College Station, TX).

Results

Survey Response

The response rate was 63% (896/1427) for PCPs and 64% (312/487) for psychiatrists, after excluding 77 PCPs and 25 psychiatrists who had invalid addresses or were no longer practicing. Among PCPs, response rates differed by sample, medical school graduation, and practice type. The response rate did not differ significantly by age, sex, region, or board certification. Among psychiatrists, response rates did not differ by any of the above demographic and professional characteristics. The application of the case weights to the analyses adjusted for these response differences and for our oversampling procedure. Demographic and professional characteristics of respondents among PCPs and psychiatrists are shown in Table 1. Psychiatrist respondents were slightly older and more likely to be

female than PCPs. PCPs and psychiatrists differed modestly by religious affiliation, and psychiatrists had somewhat lower ratings of religious importance. Psychiatrists did not differ from PCPs with respect to spirituality, race/ethnicity, immigration status, or region.

Sense of Calling among US PCPs and Psychiatrists

Table 2 displays physicians' responses to the item "For me, the practice of medicine is a calling." Among US PCPs, 40% report that they agreed strongly with this statement, whereas 43% agreed somewhat, and 17% disagreed somewhat or strongly. US psychiatrists gave a similar pattern of responses, with 42% reporting that they agreed strongly with this statement, 39% agreed somewhat, and 20% disagreed somewhat or strongly.

Table 3 shows PCPs who report a strong sense of calling, stratified by religious characteristics. Physicians who were more religious, as measured by each of the four metrics (affiliation, attendance at religious services, importance of religion, intrinsic religiosity) were more likely to report a strong sense of calling in the practice of medicine. Nearly half of Muslim (46%) and Catholic (45%) PCPs and the majority of evangelical Protestant (60%) PCPs report a strong sense of calling in their practice. These physicians also were more likely than those with no religious affiliation to report a strong sense of calling in our multivariate models (multivariate odds ratio (OR) of 3.3, 95% confidence interval [CI] 1.2–8.8 for Muslims, OR 2.4 [95% CI 1.3–4.5] for Catholics, and OR 4.5 [95% CI 2.3–8.9] for evangelical Protestants). PCPs who reported attending religious services twice per month or more were more likely to report a strong sense of calling (49% vs 23% never attend, OR 3.3 [95% CI 1.9–5.7]). PCPs who reported religion to be most important and those with higher intrinsic religiosity and spirituality also were more likely to report a strong sense of calling (64% most important vs 27% not very important, OR 5.0 [95% CI 2.9–8.8] for importance of religion; 56% high vs 31% low, OR 2.8 [95% CI 1.9–4.0] for intrinsic religiosity; 63% high vs 22% low, OR 5.5 [95% CI 3.5–8.6] for spirituality).

Table 4 shows psychiatrists who report a strong sense of calling, stratified by religious characteristics. As with PCPs, we found that psychiatrists who were more religious by any of the four measures (affiliation, attendance at religious services, importance of religion, intrinsic religiosity) also were more likely to report a strong sense of calling. Psychiatrists with high spirituality also were more likely to report a strong sense of calling (68% high vs 21% low, OR 7.8 [95% CI 3.7–16.3]).

Discussion

The data in our sample suggest that more than 40% of both US PCPs and psychiatrists agree strongly with the statement, "For me, the practice of medicine is a calling." In both samples of PCPs and psychiatrists, physicians who rated themselves as more religious or spiritual were more likely than their nonreligious counterparts to identify with a strong sense of calling in their medical practice.

In light of the theological roots of calling, it is perhaps not surprising that a study of the members of various Christian congregations found that those with higher levels of religiosity were more likely to perceive their work as a calling and to view work in a distinct

manner.²⁴ Similarly, in our study, regardless of their affiliation, PCPs and psychiatrists who scored higher on measures of religiosity or spirituality also were more likely to strongly agree that medicine is a calling. Because religions generally encourage their adherents to reflect on the purposes of life that extend beyond the self,²⁵ an individual who chooses or continues medicine as a career after such reflection may make sense of his or her decision as a response to a “calling.”

It is worthwhile to note that although more religious or more spiritual physicians were more likely to strongly endorse that the practice of medicine was a calling, a majority of even the least religious physicians still appear to agree at least somewhat that medical practice is a calling. This may reflect the fact that “calling” is a concept used widely outside religious contexts. This finding also may be because medicine involves serving suffering and vulnerable populations,^{1,10^A} which is traditionally associated with intrinsic meaning and reward. Future studies are needed to examine whether physicians are more likely than professionals in other fields to identify their work as a calling. An article published in 1955 noted that in many medical autobiographies, physicians historically expressed a special sense of calling to the medical profession.²⁶

Religious traditions provide theological resources, rituals, community practices, and paradigmatic exemplars that may cultivate the vocational calling in medical practitioners.²⁷ For example, in one qualitative study, the authors interviewed 49 healthcare providers from six faith-based and four secular healthcare institutions to explore the ways that these providers explained their decision to practice medicine as a response to a religious calling to medicine. They found that faith-based community health centers appeared to provide a vocational context in which some of these providers were able to express their religious calling to ministry through their work.²⁸ A sense of calling in work may be a relatively unexplored intrinsic motivating factor for physicians, and religious traditions may offer resources and practices that cultivate a strong sense of calling during the process of medical education. Further research is needed to understand the specific practices and contextual factors that allow for calling-oriented physicians to integrate their religious commitments with their medical vocation.

Given the moral pluralism in medicine, how can a sense of calling be sustained in the next generation of physicians, many of whom enter medical schools with varying levels of religious or nonreligious commitments? Kinghorn and colleagues have argued that medical education “should be characterized by open pluralism: a commitment to explore, understand, and hear the voices of the particular moral communities that constitute our culture.”²⁹ Part of this commitment could include exposure to various secular and religious worldviews in medicine and in communities from which medical students are deriving and cultivating their sense of calling to generate meaning and significance in their future work as physicians.³⁰ To sustain a strong sense of calling in the midst of sweeping changes in American health care, medical educators also may consider how to invite students to connect their practices of medicine with their religious identity in the context of their specific moral communities.

^ARefs 10 and 26 were identical. Ref deleted and subsequent refs renumbered.

To our knowledge, only one medical school has launched innovative curricula specific to students' particular religious traditions to cultivate this sense of calling and meaning during the course of their medical education.³¹ Although the program does conceptualize calling using religious ideas, its structure could be applied in nonreligious medical programs. Key to the program are the principles of service and a connection to the community to combat isolation in the medical environment and root the concept of the medical profession in ideas about the practice of participating in the local community. This focus can be aligned with the three common themes within calling that Hunter and colleagues described without having to integrate religious language or discipline.¹⁴

Our study has several limitations. Given the problem of survey burden in our respondent pool, we opted to use a single-item measure of calling that has been less extensively tested than other measures of this construct, some of which also measure multiple domains of calling.^{13,32} Moreover, contemporary definitions of calling have broadened to include a strong sense of purpose or self-fulfillment that enables one to work with a vision, without necessarily referencing religious concepts.¹³ This study, however, did not assess physicians' endorsement of calling specifically as a religious (or nonreligious) concept because we left the definition of calling open to interpretation by the respondent. Likewise, our single-item measure of spirituality does not distinguish between the various definitions described in qualitative research²¹; however, given that compassion and selflessness were common themes across definitions of both spirituality²¹ and a sense of calling,¹⁴ spirituality broadly speaking may still have a meaningful relation with a sense of calling. Regardless, this is not addressed in our analysis. Also, nonresponders may differ from responders in ways that bias our results. Lastly, our study is cross-sectional and cannot be used to make definitive causal inferences on whether religious characteristics lead physicians to develop a strong sense of calling.

Conclusions

In this national study of PCPs and psychiatrists, we found that physicians who considered themselves religious were more likely to report a strong sense of calling in the practice of medicine. Although this cross-sectional study cannot be used to make definitive causal inferences between religion and developing a strong sense of calling, physicians who consider themselves religious are more likely to embrace the concept of calling in their practice of medicine.

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Key Points

- Physicians and psychiatrists who scored higher on measures of religiosity were more likely to report a strong sense of calling in the practice of medicine.
- Muslim, Catholic, and evangelical Protestant physicians were more likely to report a strong sense of calling in the practice of medicine than those with no religious affiliation.
- Primary care physicians and psychiatrists who report higher spirituality were more likely to report a strong sense of calling.

Table 1

Respondent characteristics of 896 US PCPs and 312 US psychiatrists, 2009–2010

	PCPs, n (%) ^a	Psychiatrists, n (%) ^a
Demographics		
Age, y		
25–36	226 (25)	80 (26)
37–44	224 (25)	42 (13)
45–53	225 (25)	92 (29)
54–65	221 (25)	98 (31)
Sex		
Male	572 (64)	179 (57)
Female	324 (36)	133 (43)
Region		
South	295 (33)	89 (29)
Northeast	198 (22)	102 (33)
Midwest	216 (24)	61 (20)
West	187 (21)	60 (19)
Race/ethnicity		
White/non-Hispanic	625 (71)	198 (64)
Black/non-Hispanic	53 (6)	23 (7)
Asian American	142 (16)	64 (21)
Hispanic/Latino	41 (5)	17 (5)
Other	22 (2)	8 (3)
Immigration history		
Born in US	637 (72)	214 (69)
Immigrated to US at any age	249 (28)	96 (31)
Religious and spiritual characteristics		
Religious affiliation		
None	96 (11)	48 (16)
Hindu	42 (5)	24 (8)
Jewish	97 (11)	41 (13)
Muslim	60 (7)	8 (3)
Roman Catholic/Eastern Orthodox	212 (24)	68 (22)
Protestant, evangelical	95 (11)	20 (7)
Protestant, nonevangelical	227 (26)	71 (23)
Other	39 (5)	27 (9)
Attendance at religious services		
Never	118 (14)	53 (17)
1×/mo	413 (48)	162 (52)

	PCPs, n (%) ^a	Psychiatrists, n (%) ^a
2×/mo	338 (39)	94 (30)
Importance of religion		
Not very important/not applicable, I have no religion	215 (25)	100 (32)
Fairly important	283 (32)	104 (34)
Very important	251 (29)	80 (26)
Most important	127 (15)	25 (8)
Intrinsic religiosity		
Low	377 (44)	135 (44)
Moderate	184 (21)	80 (26)
High	302 (35)	90 (30)
Spirituality		
Low	294 (34)	109 (35)
Moderate	363 (42)	119 (39)
High	213 (25)	80 (26)

These data come from two national surveys among stratified random samples of 1504 US PCPs (2009–2010) and 512 US psychiatrists (2010). Percentages in this table are not adjusted for survey design. PCP, primary care physician.

^aBecause of rounding error, results may not sum to 100%. Numbers do not sum to 896 for PCPs and 312 for psychiatrists because of item nonresponse.

Table 2

Sense of calling among 896 US PCPs and 312 US psychiatrists, 2009–2010

“For me, the practice of medicine is a calling”	PCPs, n (%) ^a	Psychiatrists, n (%) ^a
Agree strongly	365 (40)	128 (42)
Agree somewhat	361 (43)	121 (39)
Disagree somewhat	99 (12)	45 (15)
Disagree strongly	40 (5)	14 (5)

^aBecause of rounding error, results may not sum to 100%. Results are adjusted for survey design. Percentages reflect estimates for the population of US PCPs and psychiatrists. PCP, primary care physician.

Table 3

Strong sense of calling among PCPs, by religious/spiritual characteristics, 2009–2010

Characteristics	n (%)	Bivariate P (χ^2)	Multivariate OR (95% CI) ^a
Religious affiliation			
None	26 (26)	<0.001	Referent
Hindu	13 (27)		1.4 (0.5–4.0)
Jewish	35 (33)		1.4 (0.7–2.9)
Muslim	25 (46)		3.3 (1.2–8.8) *
Roman Catholic/Eastern Orthodox	95 (45)		2.4 (1.3–4.5) **
Protestant, evangelical	59 (60)		4.5 (2.3–8.9) ***
Protestant, nonevangelical	94 (40)		1.7 (0.9–3.1)
Other	16 (35)		1.6 (0.6–4.0)
Attendance at religious services			
Never	28 (23)	<0.001	Referent
1×/mo	160 (37)		2.0 (1.2–3.5) *
2×/mo	173 (49)		3.3 (1.9–5.7) ***
Importance of religion			
Not very important/not applicable, I have no religion	61 (27)	<0.001	Referent
Fairly important	96 (33)		1.4 (0.9–2.1)
Very important	122 (48)		2.4 (1.5–3.7) ***
Most important	86 (64)		5.0 (2.9–8.8) ***
Intrinsic religiosity			
Low	119 (31)	<0.001	Referent
Moderate	70 (35)		1.1 (0.7–1.7)
High	172 (56)		2.8 (1.9–4.0) ***
Spirituality			
Low	70 (22)	<0.001	Referent
Moderate	155 (42)		2.5 (1.7–3.7) ***
High	140 (63)		5.5 (3.5–8.6) ***

These data come from a national survey in 2009–2010 among a stratified random sample of 1504 US PCPs who strongly agree with the statement, “For me, the practice of medicine is a calling.” Referent group is those physicians who disagree or somewhat agree with this statement. Results are adjusted for survey design. CI, confidence interval; OR, odds ratio; PCP, primary care physician.

^a Multivariate analyses also control for age, sex, region, race/ethnicity, and immigration history.

* $P < 0.05$.

** $P < 0.01$.

*** $P < 0.001$.

Table 4

Strong sense of calling among psychiatrists, by religious/spiritual characteristics, 2009–2010

Characteristics	n (%)	Bivariate P (χ^2)	Multivariate OR (95% CI) ^a
Religious affiliation			
None	10 (21)	<0.001	Referent
Hindu	14 (58)		4.3 (1.2–15.5) *
Jewish	15 (37)		2.2 (0.8–6.1)
Muslim	6 (75)		7.3 (1.0–51.6) *
Roman Catholic/Eastern Orthodox	30 (44)		2.9 (1.2–7.1) *
Protestant, evangelical	15 (75)		10.7 (2.6–44.2) ***
Protestant, nonevangelical	24 (34)		1.8 (0.7–4.7)
Other	14 (54)		3.8 (1.3–11.4) *
Attendance at religious services			
Never	14 (26)	<0.001	Referent
1×/mo	58 (36)		1.5 (0.7–3.0)
2×/mo	55 (59)		4.0 (1.8–8.9) ***
Importance of religion			
Not very important/not applicable, I have no religion	21 (21)	<0.001	Referent
Fairly important	46 (45)		2.8 (1.4–5.5) **
Very important	42 (53)		3.5 (1.8–7.1) ***
Most important	19 (76)		12.2 (4.0–37.3) ***
Intrinsic religiosity			
Low	40 (30)	<0.001	Referent
Moderate	31 (39)		1.5 (0.8–2.9)
High	54 (60)		3.5 (1.9–6.7) ***
Spirituality			
Low	23 (21)	<0.001	Referent
Moderate	51 (43)		3.0 (1.5–5.7) ***
High	54 (68)		7.8 (3.7–16.3) ***

These data come from a national survey in 2010 among a stratified, random sample of 512 US psychiatrists who strongly agree with the statement, “For me, the practice of medicine is a calling.” Referent group is those psychiatrists who disagree or somewhat agree with this statement. Results are adjusted for survey design. CI, confidence interval; OR, odds ratio.

^a Multivariate analyses also control for age, sex, region, race/ethnicity, and immigration history.

* $P < 0.05$.

** $P < 0.01$.

*** $P < 0.001$.